

		FOR OHF USE				

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**2003**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2003)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH Facility ID Number:</b> <u>0037838</u></p> <p><b>Facility Name:</b> <u>Oregon Healthcare Center</u></p> <p><b>Address:</b> <u>881 South 10th Street</u> <u>Oregon</u> <u>61061</u>        Number City Zip Code</p> <p><b>County:</b> <u>Ogle</u></p> <p><b>Telephone Number:</b> <u>(815) 732-7994</u> Fax # <u>(815) 732-3733</u></p> <p><b>IDPA ID Number:</b> <u>363806980001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>03/01/92</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Steve Lavenda</u> <b>Telephone Number:</b> <u>(847) 236 - 1111</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1144 673 1281 828">Officer or Administrator of Provider</td> <td data-bbox="1281 673 1921 722">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1144 722 1281 828"></td> <td data-bbox="1281 722 1921 755">(Type or Print Name) _____</td> </tr> <tr> <td data-bbox="1144 755 1281 828"></td> <td data-bbox="1281 755 1921 803">(Title) _____</td> </tr> <tr> <td data-bbox="1144 828 1281 1039">Paid Preparer</td> <td data-bbox="1281 828 1921 885">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1144 885 1281 1039"></td> <td data-bbox="1281 885 1921 933">(Print Name and Title) <u>Noshir R. Daruwalla, C.P.A.</u></td> </tr> <tr> <td data-bbox="1144 933 1281 1039"></td> <td data-bbox="1281 933 1921 1015">(Firm Name &amp; Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td> </tr> <tr> <td data-bbox="1144 1015 1281 1039"></td> <td data-bbox="1281 1015 1921 1039">(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td> </tr> </table> <p align="right"><b>MAIL TO: OFFICE OF HEALTH FINANCE</b>  <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>      201 S. Grand Avenue East      Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) <u>Noshir R. Daruwalla, C.P.A.</u>		(Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>		(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center

# 0037838 Report Period Beginning: 01/01/03 Ending: 12/31/03

**III. STATISTICAL DATA**

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>104</u>	Skilled (SNF)	<u>104</u>	<u>37,960</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>104</u>	TOTALS	<u>104</u>	<u>37,960</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	4 Other		
8	SNF	<u>1,378</u>	<u>83</u>	<u>1,897</u>	<u>3,358</u>	8
9	SNF/PED					9
10	ICF	<u>15,161</u>	<u>7,170</u>	<u>246</u>	<u>22,577</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,539</u>	<u>7,253</u>	<u>2,143</u>	<u>25,935</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.32%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 3/1/92

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 3/1/92 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 10 and days of care provided 1,815

Medicare Intermediary AdminaStar Federal

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/03 Fiscal Year: 12/31/03

\* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
<b>A. General Services</b>											
1	Dietary	167,081	15,449	3,498	186,028	186,028	(727)	185,301			1
2	Food Purchase		100,989		100,989	100,989	(282)	100,707			2
3	Housekeeping	128,079	25,693		153,772	153,772		153,772			3
4	Laundry	52,947	16,060		69,007	69,007		69,007			4
5	Heat and Other Utilities			75,773	75,773	75,773	247	76,020			5
6	Maintenance	52,138	20,039	4,585	76,762	76,762	(856)	75,906			6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	400,245	178,230	83,856	662,331	662,331	(1,618)	660,713			8
<b>B. Health Care and Programs</b>											
9	Medical Director			3,600	3,600	3,600		3,600			9
10	Nursing and Medical Records	871,041	23,830	5,046	899,917	899,917	(3,706)	896,211			10
10a	Therapy			504	504	504		504			10a
11	Activities	52,821	4,951		57,772	57,772		57,772			11
12	Social Services										12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	923,862	28,781	9,150	961,793	961,793	(3,706)	958,087			16
<b>C. General Administration</b>											
17	Administrative	51,032		120,000	171,032	171,032	(855)	170,177			17
18	Directors Fees										18
19	Professional Services			97,882	97,882	97,882	(69,684)	28,198			19
20	Dues, Fees, Subscriptions & Promotions			13,745	13,745	13,745	(977)	12,768			20
21	Clerical & General Office Expenses	105,119	2,263	32,788	140,170	140,170	26,983	167,153			21
22	Employee Benefits & Payroll Taxes			212,938	212,938	212,938		212,938			22
23	Inservice Training & Education										23
24	Travel and Seminar			327	327	327	5	332			24
25	Other Admin. Staff Transportation			4,018	4,018	4,018	319	4,337			25
26	Insurance-Prop.Liab.Malpractice			11,237	11,237	11,237	509	11,746			26
27	Other (specify):*						10,612	10,612			27
28	<b>TOTAL General Administration</b>	156,151	2,263	492,935	651,349	651,349	(33,088)	618,261			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,480,258	209,274	585,941	2,275,473	2,275,473	(38,412)	2,237,061			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

Oregon Healthcare Center

#0037838

Report Period Beginning:

01/01/03

Ending:

12/31/03

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			48,872	48,872		48,872	(1,133)	47,739			30
31	Amortization of Pre-Op. & Org.							3,436	3,436			31
32	Interest			23,045	23,045		23,045	58,014	81,059			32
33	Real Estate Taxes			30,205	30,205		30,205	2,486	32,691			33
34	Rent-Facility & Grounds			341,640	341,640		341,640	(341,640)				34
35	Rent-Equipment & Vehicles							390	390			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			443,762	443,762		443,762	(278,447)	165,315			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		41,328	115,908	157,236		157,236		157,236			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			56,940	56,940		56,940		56,940			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		41,328	172,848	214,176		214,176		214,176			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,480,258	250,602	1,202,551	2,933,411		2,933,411	(316,859)	2,616,552			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center

# 0037838

Report Period Beginning: 01/01/03

Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(27,455)	30		9
10	Interest and Other Investment Income	(20,282)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(282)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(100)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(270)	21		24
25	Fund Raising, Advertising and Promotional	(919)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,887)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(9,730)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (62,925)</b>		<b>\$</b>	<b>30</b>

OHF USE ONLY					
48		49	50	51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(253,934)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (253,934)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (316,859)</b>		<b>37</b>

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Oregon Healthcare Center  
 ID# 003788  
 Report Period Beginning: 01/01/03  
 Ending: 12/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1	Finance Charge	\$ (169)	21
2	Public TV	(73)	5
3	Veterans Expense	(3,277)	10
4	Replacement Tax ( Bldg Co.)	(3,942)	21
5	Capitalized R&M	(1,610)	6
6			6
7			7
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100			100
101	Total	(9,730)	101

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Oregon Healthcare Center

# 0037838 Report Period Beginning:

01/01/03

Ending:

12/31/03

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary					(727)							(727)	1
2	Food Purchase	(282)											(282)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(732)			979								247	5
6	Maintenance	(1,610)			754								(856)	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(2,624)</b>			<b>1,733</b>	<b>(727)</b>							<b>(1,618)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(3,277)				(429)							(3,706)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>	<b>(3,277)</b>				<b>(429)</b>							<b>(3,706)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative				(855)								(855)	17
18	Directors Fees													18
19	Professional Services			6,667	(76,351)								(69,684)	19
20	Fees, Subscriptions & Promotions	(1,019)			42								(977)	20
21	Clerical & General Office Expenses	(8,268)	3,303		31,948								26,983	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar				5								5	24
25	Other Admin. Staff Transportation				319								319	25
26	Insurance-Prop.Liab.Malpractice				509								509	26
27	Other (specify):*				10,612								10,612	27
28	<b>TOTAL General Administration</b>	<b>(9,287)</b>	<b>3,303</b>	<b>6,667</b>	<b>(33,771)</b>								<b>(33,088)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(15,188)</b>	<b>3,303</b>	<b>6,667</b>	<b>(32,038)</b>	<b>(1,156)</b>							<b>(38,412)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Oregon Healthcare Center# 0037838

Report Period Beginning:

01/01/03

Ending:

12/31/03

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(27,455)	25,222		1,100								(1,133)	30
31	Amortization of Pre-Op. & Org.		3,436										3,436	31
32	Interest	(20,282)	46,416	31,015	865								58,014	32
33	Real Estate Taxes				2,486								2,486	33
34	Rent-Facility & Grounds		(341,640)										(341,640)	34
35	Rent-Equipment & Vehicles				390								390	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>(47,737)</b>	<b>(266,566)</b>	<b>31,015</b>	<b>4,841</b>								<b>(278,447)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>													<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(62,925)</b>	<b>(263,263)</b>	<b>37,682</b>	<b>(27,197)</b>	<b>(1,156)</b>							<b>(316,859)</b>	<b>45</b>

Facility Name & ID Number Oregon Healthcare Center

# 0037838

Report Period Beginning:

01/01/03

Ending:

12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Oregon Associates		Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 Rent	\$ 341,640	Oregon Associates	100.00%	\$	\$ (341,640)
2	V	32 Interest Income	75,520	Oregon Associates	100.00%		(75,520)
3	V	32 Interest Expense		Oregon Associates	100.00%	121,936	121,936
4	V	21 Replacement Tax		Oregon Associates	100.00%	3,942	3,942
5	V	30 Depreciation		Oregon Associates	100.00%	25,222	25,222
6	V	31 Amortization		Oregon Associates	100.00%	3,436	3,436
7	V	21 Gain/Loss in Partnership	639	Oregon Associates	100.00%		(639)
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 417,799			\$ 154,536	\$ * (263,263)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	19 PROFESSIONAL FEES	\$	SFO ASSOCIATES	100.00%	\$ 6,667	\$ 6,667	15
16	V	32 INTEREST				152,565	152,565	16
17	V							17
18	V							18
19	V							19
20	V	32 INTEREST	121,550				(121,550)	20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 121,550			\$ 159,232	\$ * 37,682	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	S.W. MANAGEMENT	100.00%	\$ 979	\$ 979
16	V	6 REPAIRS AND MAINT.				754	754
17	V	17 CHIEF FINANCIAL OFFICER				11,026	11,026
18	V	19 PROFESSIONAL FEES				349	349
19	V	20 FEES, SUBSCRIPTIONS, DUES				42	42
20	V	21 CLERICAL AND GENERAL				31,948	31,948
21	V	24 EDUCATION AND SEMINARS				5	5
22	V	25 TRANSPORTATION				319	319
23	V	26 INSURANCE - PROPERTY				509	509
24	V	27 PAYROLL TAXES				8,065	8,065
25	V	30 DEPRECIATION				1,100	1,100
26	V	32 INTEREST EXPENSE				865	865
27	V	33 REAL ESTATE TAXES				2,486	2,486
28	V	35 AUTO LEASE				390	390
29	V						
30	V	17 SALARY - SHELDON WOLFE				42,869	42,869
31	V	17 SALARY - RONNIE KLEIN				5,250	5,250
32	V	27 EMP. BEN.-SHELDON WOLFE				1,806	1,806
33	V	27 EMP. BEN.-RONNIE KLEIN				741	741
34	V						
35	V	17 MANAGEMENT FEES	60,000				(60,000)
36	V	19 HOME OFFICE FEES	76,700				(76,700)
37	V						
38	V						
39	Total		\$ 136,700			\$ 109,503	\$ * (27,197)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 DIETARY SUPPLEMENTS	\$ 7,274	S & E MEDICAL SUPPLY	100.00%	\$ 6,546	\$ (727)
16	V	3 HOUSEKEEPING	3,102	S & E MEDICAL SUPPLY	100.00%	3,102	
17	V	10 MEDICAL SUPPLIES	2,146	S & E MEDICAL SUPPLY	100.00%	1,716	(429)
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 12,521			\$ 11,365	\$ * (1,156)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

**VII. RELATED PARTIES (continued)**

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Oregon Healthcare Center

# 0037838

Report Period Beginning: 01/01/03

Ending: 12/31/03

**VII. RELATED PARTIES (continued)**

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number      Oregon Healthcare Center      #      0037838      Report Period Beginning:      01/01/03      Ending:      12/31/03

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sheldon Wolfe	President	Administrative	31.74%	see attached	4.00	6.66%	SW Mgmt	\$ 42,869	17-7	1
2	Ronnie Klein	Treasurer	Administrative	15.87%	see attached	3.50	8.75%	see attached	65,250	17-3, 17-7	2
3	Mo Herman	CFO	Financial	2.40%	see attached	2.90	7.25%	SW Mgmt	11,026	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 119,145		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME. ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center

# 0037838 Report Period Beginning: 01/01/03

Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center

# 0037838 Report Period Beginning: 01/01/03

Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization SFO ASSOCIATES  
 Street Address 7434 N. SKOKIE BLVD.  
 City / State / Zip Code SKOKIE, IL. 60077  
 Phone Number ( 847) 982-2300  
 Fax Number ( 847) 982-2304

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	NOTE RECEIVABLE	6,500,000	3	\$ 21,668	\$ 2,000,000	\$ 6,667	1
2	32	INTEREST	NOTE RECEIVABLE	6,500,000	3	495,835	2,000,000	152,565	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 517,503	\$	\$ 159,232	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center

# 0037838 Report Period Beginning: 01/01/03

Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization S.W. MANAGEMENT  
 Street Address 7434 N. SKOKIE BLVD.  
 City / State / Zip Code SKOKIE, IL. 60077  
 Phone Number ( 847) 982-2300  
 Fax Number ( 847) 982-2304

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5 UTILITIES	AVAIALE BED DAYS	525,600	8	\$ 13,562	\$	37,960	\$ 979	1
2	6 REPAIRS AND MAINT.	AVAIALE BED DAYS	525,600	8	10,440		37,960	754	2
3	17 CHIEF FINANCIAL OFFICER	AVAIALE BED DAYS	525,600	8	152,661	152,661	37,960	11,026	3
4	19 PROFESSIONAL FEES	AVAIALE BED DAYS	525,600	8	4,839		37,960	349	4
5	20 FEES, SUBSCRIPTIONS, DUES	AVAIALE BED DAYS	525,600	8	579		37,960	42	5
6	21 CLERICAL AND GENERAL	AVAIALE BED DAYS	525,600	8	442,356	384,906	37,960	31,948	6
7	24 EDUCATION AND SEMINARS	AVAIALE BED DAYS	525,600	8	75		37,960	5	7
8	25 TRANSPORTATION	AVAIALE BED DAYS	525,600	8	4,412		37,960	319	8
9	26 INSURANCE - PROPERTY	AVAIALE BED DAYS	525,600	8	7,051		37,960	509	9
10	27 PAYROLL TAXES	AVAIALE BED DAYS	525,600	8	111,671		37,960	8,065	10
11	30 DEPRECIATION	AVAIALE BED DAYS	525,600	8	15,225		37,960	1,100	11
12	32 INTEREST EXPENSE	AVAIALE BED DAYS	525,600	8	11,976		37,960	865	12
13	33 REAL ESTATE TAXES	AVAIALE BED DAYS	525,600	8	34,428		37,960	2,486	13
14	35 AUTO LEASE	AVAIALE BED DAYS	525,600	8	5,396		37,960	390	14
15									15
16	17 SALARY - SHELDON WOLFE	AVG. HOURS WORKED	60	9	643,036	643,036	4	42,869	16
17	17 SALARY - RONNIE KLEIN	AVG. HOURS WORKED	40	7	60,000	60,000	4	5,250	17
18	27 EMP. BEN.-SHELDON WOLFE	AVG. HOURS WORKED	60	9	27,083		4	1,806	18
19	27 EMP. BEN.-RONNIE KLEIN	AVG. HOURS WORKED	40	7	8,473		4	741	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,553,263	\$ 1,240,603		\$ 109,503	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center

# 0037838 Report Period Beginning: 01/01/03

Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization S & E MEDICAL SUPPLY  
 Street Address 3100 COMMERCIAL AVENUE  
 City / State / Zip Code NORTHBROOK, ILLINOIS 60062  
 Phone Number ( 847) 982-9300  
 Fax Number (

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<u>DIETARY SUPPLEMENTS</u>	<u>DIRECT ALLOCATION</u>						6,546	1
2	<u>HOUSEKEEPING</u>	<u>DIRECT ALLOCATION</u>						3,102	2
3	<u>MEDICAL SUPPLIES</u>	<u>DIRECT ALLOCATION</u>						1,716	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>					\$	\$	\$ 11,365	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center

# 0037838 Report Period Beginning: 01/01/03

Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center

# 0037838 Report Period Beginning: 01/01/03

Ending: 12/31/03

**VIII. ALLOCATION OF INDIRECT COSTS**

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center

# 0037838 Report Period Beginning: 01/01/03

Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center

# 0037838 Report Period Beginning: 01/01/03

Ending: 12/31/03

**VIII. ALLOCATION OF INDIRECT COSTS**

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center

# 0037838 Report Period Beginning: 01/01/03

Ending: 12/31/03

**VIII. ALLOCATION OF INDIRECT COSTS**

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center

# 0037838 Report Period Beginning: 01/01/03

Ending: 12/31/03

**VIII. ALLOCATION OF INDIRECT COSTS**

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/03 Ending: 12/31/03

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

	1	2	3	4	5	6		8	9	10									
						Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES							NO	Original				Balance
	<b>A. Directly Facility Related</b>																		
	<b>Long-Term</b>																		
1	Oregon Associates	X					\$	\$ 508,917		6.00%	\$ 23,045	1							
2												2							
3												3							
4												4							
5	See Supplemental Schedule							1,353,846			275,366	5							
	<b>Working Capital</b>																		
6												6							
7												7							
8	See Supplemental Schedule											8							
9	TOTAL Facility Related						\$	\$ 1,862,763			\$ 298,411	9							
	<b>B. Non-Facility Related*</b>																		
10												10							
11	Interest Income										(20,282)	11							
12												12							
13	See Supplemental Schedule										(197,070)	13							
14	TOTAL Non-Facility Related						\$	\$			(217,352)	14							
15	TOTALS (line 9+line14)						\$	\$ 1,862,763			\$ 81,059	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #           

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **Oregon Healthcare Center**# **0037838**

Report Period Beginning:

**01/01/03**

Ending:

**12/31/03**

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

## A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1	Allocated SFO	X		Interest Expense			\$	\$			\$ 152,565	1								
2	Allocated SW Management	X		Interest Expense							865	2								
3	Oregon Associates	X		Interest Expense				1,353,846			121,936	3								
4												4								
5												5								
6												6								
7	TOTAL Long-Term							1,353,846			275,366	7								
	<b>Working Capital</b>																			
8							\$	\$			\$	8								
9												9								
10												10								
11												11								
12												12								
13												13								
14	TOTAL Working Capital											14								
	<b>B. Non-Facility Related*</b>																			
15	Allocated SFO			Interest Income			\$	\$			\$ (121,550)	15								
16	Oregon Associates			Interest Income							(75,520)	16								
17												17								
18												18								
19												19								
20	TOTAL Non-Facility Related										(197,070)	20								

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Oregon Healthcare Center COUNTY Ogle

FACILITY IDPH LICENSE NUMBER 0037838

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>16-04-476-009</u>	<u>Long Term Care Property</u>	\$ <u>29,795.14</u>	\$ <u>29,795.14</u>
2. <u>10-28-412-049-0000</u>	<u>allocation from SW Management</u>	\$ <u>35,796.02</u>	\$ <u>2,486.46</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>65,591.16</u>	\$ <u>32,281.60</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?  X  YES   NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Oregon Healthcare Center COUNTY Ogle

FACILITY IDPH LICENSE NUMBER 0037838

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES        NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name &amp; ID Number Oregon Healthcare Center

# 0037838 Report Period Beginning:

01/01/03 Ending:

12/31/03

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,900 B. General Construction Type: Exterior Brick Frame Steel Stud Number of Stories 1C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NoneF. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:1. Total Amount Incurred: 103,078 2. Number of Years Over Which it is Being Amortized: 303. Current Period Amortization: 3,436 4. Dates Incurred: 1992Nature of Costs: Loan Costs (Oregon Associates)

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

## XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1992</u>	<u>\$ 50,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 50,000</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various		1992		6,160		20	34	34	6,160	9
10	Various		1993		26,517		20	1,325	1,325	14,193	10
11	Various		1994		5,324		20	266	266	2,780	11
12	Various		1995		3,498		20	175	(175)	1,502	12
13	Various		1996		2,042		20	102	102	747	13
14	Various		1997		2,880		20	144	144	948	14
15	Various		1998		65,055		20	3,253	3,253	20,045	15
16	Various		1999		36,058		20	1,803	1,803	8,640	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	2	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37				\$	\$		\$	\$	\$	37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)			1,008,880	25,222		25,222		301,460	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)			38,196	957		1,290	333	10,498	68
69	Financial Statement Depreciation				2,306			(2,306)		69
70	TOTAL (lines 4 thru 69)			\$ 1,194,610	\$ 28,485		\$ 33,614	\$ 4,779	\$ 366,973	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 1,194,610	\$ 28,485		\$ 33,614	\$ 5,129	\$ 366,973		1
2	Model 10Kpa Code A/R	2001 1,189		20	59	59	144		2
3	Generator Repair	2001 1,010		20	51	51	110		3
4	Motor	2001 783		20	39	39	104		4
5	Glass Thermo Unit	2001 868		20	43	43	109		5
6	Install Board	2001 816		20	41	41	96		6
7	Gas Controller	2001 739		20	37	37	83		7
8	Clutch & Output Brd	2001 1,138		20	57	57	128		8
9	Vinyl Flooring	2001 912		20	46	46	133		9
10	Wall-Replaced	2002 5,000		20	250	250	396		10
11	Air Conditioners	2002 1,470		20	147	147	294		11
12	Air Conditioners	2002 1,366		20	137	137	216		12
13	Roof Exhaust Fan	2003 3,128		20	156	156	156		13
14	Condensor-Walk-In Freezer	2003 3,193		20	152	152	152		14
15	Radiator	2003 3,473		20	87	87	87		15
16	Hot Water Repair	2003 1,610		20	27	27	27		16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 1,221,305	\$ 28,485		\$ 34,943	\$ 6,458	\$ 369,208		34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,221,305	\$ 28,485		\$ 34,943	\$ 6,458	\$ 369,208	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,221,305	\$ 28,485		\$ 34,943	\$ 6,458	\$ 369,208	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward	\$ 1,221,305	\$ 28,485		\$ 34,943	\$ 6,458	\$ 369,208		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 1,221,305	\$ 28,485		\$ 34,943	\$ 6,458	\$ 369,208		34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 1,221,305	\$ 28,485		\$ 34,943	\$ 6,458	\$ 369,208	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,221,305	\$ 28,485		\$ 34,943	\$ 6,458	\$ 369,208	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward	\$ 1,221,305	\$ 28,485		\$ 34,943	\$ 6,458	\$ 369,208		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 1,221,305	\$ 28,485		\$ 34,943	\$ 6,458	\$ 369,208		34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12F, Carried Forward	\$ 1,221,305	\$ 28,485		\$ 34,943	\$ 6,458	\$ 369,208		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 1,221,305	\$ 28,485		\$ 34,943	\$ 6,458	\$ 369,208		34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12G, Carried Forward	\$ 1,221,305	\$ 28,485		\$ 34,943	\$ 6,458	\$ 369,208		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 1,221,305	\$ 28,485		\$ 34,943	\$ 6,458	\$ 369,208		34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12H, Carried Forward	\$ 1,221,305	\$ 28,485		\$ 34,943	\$ 6,458	\$ 369,208		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 1,221,305	\$ 28,485		\$ 34,943	\$ 6,458	\$ 369,208		34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12I, Carried Forward	\$ 1,221,305	\$ 28,485		\$ 34,943	\$ 6,458	\$ 369,208		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 1,221,305	\$ 28,485		\$ 34,943	\$ 6,458	\$ 369,208		34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 1,221,305	\$ 28,485		\$ 34,943	\$ 6,458	\$ 369,208	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,221,305	\$ 28,485		\$ 34,943	\$ 6,458	\$ 369,208	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Oregon Healthcare Center

# 0037838

Report Period Beginning:

01/01/03

Ending:

12/31/03

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	104	1992		\$ 1,008,880	\$ 25,222		\$ 25,222	\$	\$ 298,460	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-BLDG, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$	\$	\$	3,000	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	301,460	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Oregon Healthcare Center

# 0037838

Report Period Beginning:

01/01/03

Ending:

12/31/03

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	SW Mgmt			1995	\$ 31,260	\$ 802	35	\$ 893	\$ 91	\$ 7,730	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Allocated from SW Management			1995	3,335	51	20	199	148	1,679	9
10	Allocated from SW Management			1996	582	15	20	29	14	220	10
11	Allocated from SW Management			1997	839	33	20	60	27	376	11
12	Allocated from SW Management			1998	577	15	20	29	(14)	166	12
13	Allocated from SW Management			1999	1,603	41	20	80	39	327	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9				
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$		37			
38									38			
39									39			
40									40			
41									41			
42									42			
43									43			
44									44			
45									45			
46									46			
47									47			
48									48			
49									49			
50									50			
51									51			
52									52			
53									53			
54									54			
55									55			
56									56			
57									57			
58									58			
59									59			
60									60			
61									61			
62									62			
63									63			
64									64			
65									65			
66									66			
67									67			
68									68			
69									69			
70	TOTAL (lines 4 thru 69)	\$	38,196	\$	957	\$	1,290	\$	305	\$	10,498	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 121,549	\$ 20,509	\$ 9,839	\$ (10,670)	10	\$ 94,931	71
72	Current Year Purchases	102	102	7	(95)	10	7	72
73	Fully Depreciated Assets	247,015				10	247,015	73
74								74
75	TOTALS	\$ 368,666	\$ 20,611	\$ 9,846	\$ (10,765)		\$ 341,953	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	VAN-WHEELCHAIR LIFT	2003	\$ 4,635	\$	\$ 155	\$ 155	5	\$ 155	76
77	Facility	E350 VAN	2003	26,099	26,099	2,796	(23,303)	5	2,796	77
78										78
79										79
80	TOTALS			\$ 30,734	\$ 26,099	\$ 2,951	\$ (23,148)		\$ 2,951	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,670,705	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 75,195	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 47,740	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (27,455)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 714,112	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A  
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
 If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:  
 Beginning \_\_\_\_\_  
 Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>/2004</u>	\$ _____
13.	<u>/2005</u>	\$ _____
14.	<u>/2006</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.  
 This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
 by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?  YES  NO  
 16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Allocated from SW Management</u>		\$	\$ <u>390</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$ <u>390</u>	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION: _____</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION: _____</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
- SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	70,921	\$		\$	70,921	1		
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				1,568				1,568	2		
3	Licensed Recreational Therapist		hrs									3		
4	Licensed Physical Therapist	39 - 03	hrs				43,419				43,419	4		
5	Physician Care		visits									5		
6	Dental Care		visits									6		
7	Work Related Program		hrs									7		
8	Habilitation		hrs									8		
9	Pharmacy	39 - 02	# of prescripts						37,167		37,167	9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10		
11	Academic Education		hrs									11		
12	Exceptional Care Program											12		
13	Other (specify): See Supplemental								4,161		4,161	13		
14	TOTAL			\$		\$	115,908	\$	41,328	\$	157,236	14		

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Oregon Healthcare Center

# 0037838

Report Period Beginning: 01/01/03

Ending:

12/31/03

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/03

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 122,479	\$ 122,479	1
2	Cash-Patient Deposits	9,494	9,494	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	561,922	561,922	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,990	13,990	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	353,853	1,589,743	8
9	Other(specify): <a href="#">See Attached Schedule</a>		33,719	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,061,738	\$ 2,331,347	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,000	13
14	Buildings, at Historical Cost		1,008,880	14
15	Leasehold Improvements, at Historical Cost	87,699	87,699	15
16	Equipment, at Historical Cost	247,510	453,510	16
17	Accumulated Depreciation (book methods)	(256,440)	(760,900)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		113,078	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(42,415)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <a href="#">See Attached Schedule</a>			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 78,769	\$ 909,852	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,140,507	\$ 3,241,199	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 140,534	\$ 140,534	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,235	13,235	28
29	Short-Term Notes Payable	508,917	508,917	29
30	Accrued Salaries Payable	44,177	44,177	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,363	5,363	31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,285	31,285	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<a href="#">See Attached Schedule</a>			36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 743,511	\$ 743,511	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable		1,353,846	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<a href="#">See Attached Schedule</a>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 1,353,846	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 743,511	\$ 2,097,357	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 396,996	\$ 1,143,842	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,140,507	\$ 3,241,199	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 377,699	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 377,699	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	19,297	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 19,297	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 396,996	24 *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Oregon Healthcare Center

# 0037838

Report Period Beginning: 01/01/03

Ending: 12/31/03

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,858,469	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,858,469	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	55,514	6
7	Oxygen	11,629	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 67,143	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	732	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	5,913	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 6,645	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	20,282	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 20,282	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Supplemental Schedule	169	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 169	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,952,708	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	662,331	31
32	Health Care	961,793	32
33	General Administration	651,349	33
<b>B. Capital Expense</b>			
34	Ownership	443,762	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	157,236	35
36	Provider Participation Fee	56,940	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,933,411	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	19,297	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 19,297	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\* Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Oregon Healthcare Center**

# **0037838**

Report Period Beginning: **01/01/03**

Ending:

**12/31/03**

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**  
(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,984	\$ 46,335	\$ 22.62	1
2	Assistant Director of Nursing				2
3	Registered Nurses	3,435	72,396	19.85	3
4	Licensed Practical Nurses	11,715	214,348	17.35	4
5	Nurse Aides & Orderlies	52,091	537,962	10.03	5
6	Nurse Aide Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants	4,485	52,821	10.68	10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor	1,945	24,847	11.73	13
14	Head Cook				14
15	Cook Helpers/Assistants	18,038	142,234	7.45	15
16	Dishwashers				16
17	Maintenance Workers	3,533	52,138	13.88	17
18	Housekeepers	13,893	128,079	8.34	18
19	Laundry	7,468	52,947	6.62	19
20	Administrator	2,000	51,032	24.53	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	6,229	105,119	16.43	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify) <a href="#">See Supplemental</a>				33
34	TOTAL (lines 1 - 33)	126,816	\$ 1,480,258 *	\$ 11.09	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	monthly \$ 3,498	01-03	35
36	Medical Director	monthly 3,600	09-03	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	101 5,046	10-03	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant	12 504	10a-03	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	113 \$ 12,648		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Nurse Aides			52
53	TOTAL (lines 50 - 52)	\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center

# 0037838

Report Period Beginning: 01/01/03

Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Debra Adkins (1/1-10/11/03)	Administrator	0	\$ 43,727	Workers' Compensation Insurance	\$ 35,638	IDPH License Fee	\$ 4,080	
Donna Vanmiddendrop (10/12-12/31/03)	Administrator	0	7,305	Unemployment Compensation Insurance	10,193	Advertising: Employee Recruitment	2,043	
				FICA Taxes	113,172	Health Care Worker Background Check	532	
				Employee Health Insurance	53,135	(Indicate # of checks performed <u>44</u> )		
				Employee Meals		Advertising	919	
				Illinois Municipal Retirement Fund (IMRF)*		Association Fees (ICLTC)	5,008	
				Misc Employee Benefits / Disability	800	Dues & Subscriptions	722	
						Inspections & Licenses	341	
						Allocated from SW Management	42	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 51,032			Less: Public Relations Expense	( )	
B. Administrative - Other						Non-allowable advertising	(919)	
Description			Amount			Yellow page advertising	( )	
Ronnie Klein - Management Fees			\$ 60,000					
SW Management - Management Fees			60,000					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 120,000	TOTAL (agree to Schedule V, line 22, col.8)	\$ 212,938	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 12,768	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Frost, Ruttenberg & Rothblett	Accounting		\$ 15,579				Out-of-State Travel	\$
Fearer, Nye, Ahlberg & Chadwick	Legal		2,125					
Ashman & Stein	Legal		3,478				In-State Travel	
SW Management	Home Office		76,700					
							Seminar Expense	327
							Allocated from SW Management	5
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 97,882	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 332

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1	2	3	4	5										
				6										
1	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
2														
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	

SEE ACCOUNTANTS' COMPILATION REPORT

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Illinois Council on Long Term Care \$5008
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 56,940  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ \_\_\_\_\_ Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' COMPILATION REPORT**